c. The costs for travel and associated expenses outside the Commonwealth for conventions, assemblies, etc. or related activities. Costs (excluding transportation) for educational purposes will be allowable costs.

Cost reports and all supplements are to be submitted annually within five (5) months after the close of the hospital's fiscal year. Extensions will not be granted. The Department will suspend payments until an acceptable cost report is filed.

B. Additional Provisions for Psychiatric Hospitals
Psychiatric hospitals will have an upper limit established at the weighted median of the array of allowable costs for all participating psychiatric hospitals. Hospitals having a Medicaid utilization of thirty-five (35) percent or higher will have an upper limit established at one-hundred and fifteen (115) percent of the weighted median. There will be no limit on depreciation.

(6) New Providers/Change of Ownership
If a hospital undergoes a change of ownership, the new owner will be reimbursed at the rate of the forrner provider. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs data, the department will base its prospective rate on a partial year. The partial year data will be annualized and indexed appropriately.

Until a fiscal year end cost report is available, newly constructed or participating providers will submit an operating budget and projected number of patient days within 30 days of enrolling as a provider. A tentative rate will be set based on data with a final rate determined after receipt of an audited cost report. The limitations described under this section will apply.

For a newly enrolled provider in a non-rebase year, costs and per diems will be trended and indexed to the base year to establish a base year per diem. The base year per diems will then be adjusted to account for historical inflationary rate increases received by other providers. For example: A provider participating for the first time in SFY 2003 rates would be based on current costs which would be trended back to 1997 to correspond to the base year costs for other providers. After determining the base year costs, costs would be trended and indexed to 1998 to

establish a prospective rate for 1998. From 1998 to the current rate year, the 1998 rate would be adjusted in the same manner as other providers; i.e. in 1999 a 3% rate increase; 2000 a 2.8%rate increase; 2001 rates were frozen; 2002 rates were frozen, etc.

(7) Out-Of State
An out-of-state rehabilitation hospital, psychiatric hospital, or critical access hospital will be reimbursed for an impatient service on a fully prospective per diem basis for the universal rate year beginning on or after April 1, 2003. The per diem rate will be the median per diem rate for the appropriate classification of hospital. The median will be calculated at the beginning of each universal rate year.

(8) For the universal rate year April 1, 2003 through June 30, 2004, rehabilitation hospitals, long-term acute care hospitals, and psychiatric hospitals will continue to be paid the per diem in effect for the rate year beginning July 1, 2002.

(9) Disproportionate Share Hospital Provisions

A. Definition. A *disproportionate share hospital* is a hospital that (a) has a Medicaid utilization rate of not less than one percent; and (b) has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision shall not apply to a hospital that did not offer non-emergency obstetric services as of December 21, 1987.

B. Hospitals are classified as follows:
   a. Type I hospitals are hospitals with 100 beds or less;
   b. Type II hospitals are hospitals with more than 100 beds that are not Type III or Type IV hospitals;
   c. Type III hospitals are state university teaching hospitals; and
   d. Type IV hospitals are state-owned mental hospitals.

C. Annually the Department shall determine a sum of funds to be allocated to each classification of hospitals in accordance with state and federal law as follows:
   a. Non state-owned acute care hospitals are allocated 43.92% of the total federal/state allotment. (Type I and Type II hospitals)
   b. State university teaching hospitals are allocated 37% of the total federal/state allotment. (Type III hospitals)

c. Mental hospitals (including private and state-owned facilities) are allocated 19.08% of the total federal/state allotment. (Type IV hospitals)
d. Any funds not distributed in any pool due to the limit in J. may be transferred to another pool and distributed according to the provisions below.

D. Disproportionate share hospital payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which patient and cost data used in the calculation was taken.

E. The Department will use patient and cost data from the most recently completed state fiscal year. DSH payments shall be made on an annual basis.

F. Payments will be distributed to Type I and Type II hospitals based upon each hospital's proportion of indigent costs determined as follows:

$$\frac{\text{Indigent Costs}}{\text{Total Indigent Costs}} \times \text{Available Fund} = \text{DSH Payment}$$

Indigent costs include the inpatient and outpatient costs of providing care to indigent patients. Indigent patients include patients without health insurance or other source of third party payment with incomes below 100% of the federal poverty level.

G. Payments will be distributed to Type III hospitals based upon each facility's percentage of the total pool funds received in SFY 1999. This percentage is applied to current allocated funds.

H. Payments will be distributed to Type IV hospitals based upon each facility's proportion of uncompensated costs. Uncompensated costs include the costs of care for indigent patients and uninsured patients.

I. Except for State Fiscal Years 2004 and 2005, payments to Type III and Type IV hospitals shall not exceed the sum of the costs of providing inpatient and outpatient services to Medicaid patients, less the amount paid under the nondisproportionate share provisions and the costs of services to both uninsured and indigent patients, less any payments made. For State Fiscal Years 2004 and 2005, payments shall not exceed the limitation in L.

Indigent patients are defined in state law as individuals without health insurance or other sources of third party payment with incomes below 100% of the federal poverty level.

Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

J. The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

K. Limit on Amount of Disproportionate Share Payment to a Hospital.
Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. *Medicaid shortfall* is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan. The *cost of services* to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. *Uninsured patients* are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

L. Funds not distributed under the above provisions due to the limit in L. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

Medicaid Days
Total Medicaid Days X Remaining Funds = DSH Payment

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). *Medicaid days* shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and though a managed care entity.

M. For state fiscal years beginning July 1, 2003 and July 1, 2004, payments to public hospitals may not exceed 175% of a hospital's uncompensated care costs as described in L.

(12) Intensity Operating Allowance Inpatient Supplement.

Beginning July 1, 2003, a state designated pediatric hospital that is state-owned or operated and qualifies as a Type III DSH hospital shall receive an enhanced payment for the current rate year. This payment shall be an amount that is equal to the difference between the payments made by Medicaid and an estimate of Medicare payments for the same services based on Medicare principles of reimbursement as specified in 42 CFR 447.272. The limitation in 42 CFR 447.272 will be applied on a facility-specific basis.

Any payments made under this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services

Payments made under this section shall be prospectively determined quarterly amounts, subject to the same limitations and conditions as above.

In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

(12) Intensity Operating Allowance Inpatient Supplement (cont.)

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

1. Determined on a per diem or per discharge basis equal to the unreimbursed costs of providing care to Medicaid recipients under the age of 18; plus

2. $250,000 ($1 million annually).

Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.

(13) Payment Not to Exceed Charges

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges-plus-disproportionate share.

(14) Limit on Amount of Disproportionate Share Payment to a Hospital

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)

Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.

Unrecovered Cost of Uninsured/Indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

(15) Supplemental Payment for Urban Trauma Center Hospitals

Supplemental payments are provided for Type III hospitals that qualify as urban trauma centers.

A. A hospital qualifies as an urban trauma center if it meets the following:

1. The hospital is designated as a Level I Trauma Center by the American College of Surgeons;
2. The hospital has a Medicaid utilization rate greater than 25%; and
3. At least 50% of its Medicaid population are residents of the county in which the hospital is located.

Medicaid utilization rate is the rate derived by dividing a hospital's total Medicaid days by the total patient days, which includes days reimbursed through a managed care entity and fee-for-service.

B. The supplemental payment amount will be determined as follows:

Step 1: The average payment rate per Medicare case with case mix removed will be calculated by dividing all Medicare payments subject to case mix by the Medicare case mix index and adding to this amount all Medicare pass-through payments utilizing data obtained from the most recent cost report. The result will be divided by Medicare cases for the corresponding period.

Step 2: The average payment rate per Medicaid case with case mix removed will be calculated by dividing total Medicaid payments subject to case mix by the Medicaid case mix index calculated utilizing Medicare relative weights and adding to this amount all other Medicaid payments. The result will be divided by the number Medicaid cases for the corresponding period.

Step 3: The difference between the average payment rate per Medicare case with case mix removed and the average payment rate per Medicaid case with case mix removed will be multiplied by the Medicaid case mix and the number of Medicaid cases. The result is the gap between the Upper Payment Limit (UPL) and Medicaid payments for the applicable period.

Step 4: The difference between the average charge per Medicaid case and the average Medicaid payment rate per Medicaid case will be multiplied by the number of Medicaid cases. The result is the charge gap for the applicable period.

Step 5: The total supplemental payment will be equal to the lesser of the UPL Gap calculated in Step 3 and the Charge Gap calculated in Step 4.

C. Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

D. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Centers for Medicare and Medicaid Services, the Department shall adjust the payments made to any hospitals to qualify for FFP.

(16) Upper Payment Limit

The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits.

(18) Supplemental payments for non-state government-owned hospitals.

A. The Department provides quarterly supplemental payments to certain non-state government-owned hospitals for services provided to Medicaid patients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for services to Medicaid patients and the maximum allowable under applicable federal regulations in accordance with 42 CFR 447.272.

To qualify for a supplemental payment, a hospital must be a non-state government-owned hospital and must have entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all qualifying hospitals for the same fiscal year.

A payment made to a hospital under this provision when combined with other payments made under the non-disproportionate provisions of the state plan shall not exceed the limit specified in 42 CFR 447.272.

These supplemental payments shall end on June 30, 2005.

B. Commencing July 1, 2005, the Department will provide inpatient supplemental payments to non-state, government-owned hospitals for services provided to Medicaid patients. These payments will be determined by calculating the difference between the aggregate amount paid for inpatient services provided to Medicaid patients and the estimated aggregate payment amount for such services if payments were based on Medicare payment principles, or the upper payment limit gap (UPL Gap).

The estimated aggregate payment amount for Medicaid services if payment were based on Medicare payment principles will be determined by calculating the sum of the average payments determined by applying Medicare payment principles for each hospital multiplied by the number of estimated cases for each hospital for the applicable payment period. The average payment

rate under Medicare for acute care inpatient hospital stays for each hospital will be determined by calculating the hospital-specific payment rate in accordance with the Medicare Inpatient Prospective Payment system. In determining this amount the case mix index for the Medicaid population will be calculated utilizing Medicare relative weights. The average payment rate for services provided by hospital units excluded from the Medicare Inpatient Prospective Payment system will be calculated in accordance with Medicare cost based principles of reimbursement.

The amount of the aggregate UPL Gap will be distributed to individual non-state, government-owned hospitals based on the individual hospital's fee-for-service inpatient days as a proportion of total fee-for-service inpatient days for non-state, government-owned hospitals. In the event such a payment would exceed an individual hospital's charge limit, the amount in excess of the individual hospital's charge limit will be allocated to other non-state, government-owned hospitals eligible to receive additional payments without exceeding their charge limit. Individual hospital payments may also be reduced in order to assure that an individual hospital's net payments do not exceed 2004 net payments. In the event a hospital's net payments are reduced to assure net payments do not exceed 2004 net payments, the amount in excess of the hospital's 2004 net payment will be allocated to other non-state, government-owned hospitals eligible for payment.

Inpatient supplemental payments described above will be made at least quarterly.

A payment made to a hospital under this provision when combined with other payments under the non-disproportionate provisions of the state plan shall not exceed the limit specified in 42 CFR 447.272.